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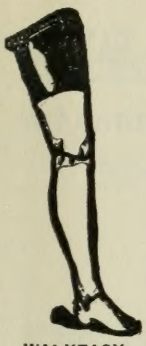

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THE
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PRESIDENTIAL ADDRESS.*

By H. K. McDONALD, M. D., C. M., Lunenburg, N. S.

Members of the Lunenburg-Queens Medical Society and of the Profession:

GENTLEMEN,—When you elected me president of this society at the last regular meeting the first thought that occurred to me was that it would be necessary for me to deliver an address at our next place of meeting. Much, gentlemen, as I esteemed the honor you conferred on me by electing me president, I could not help but think how very unfortunate it was, for "the time honored custom of presidents to deliver an address," that such a duty should fall upon me, and I can assure you that it is with a great deal of hesitation that I attempt the same, following in the wake of our ex-president, Dr. March, whose presidential address at our last meeting in Lunenburg would have done honor to any president, of any society, on any occasion whatever.

Those who were present on the occasion when this society met in Lunenburg will remember it, and those who were not present certainly missed an up-to-date, practical paper, but thanks to our efficient secretary and the Maritime Medical News, they had an opportunity of reading the address in that journal, and many were the favorable comments I heard from members of the profession outside of our local society upon the same.

In glancing at our programme you will notice this meeting, designated as a special meeting, of the Lunenburg-Queens Medical

*Delivered before meeting of Lunenburg-Queens Medical Society, Chester, Aug. 5th. 1903.

Society. As president of this society I have to thank the local committee, the medical men of Chester, for inviting us here on this occasion, and for the arrangement and successful carrying out of our programme. More than once since this society met in Bridgewater last, I, with others, have talked over our proposed meeting in Chester. We have looked forward with a great deal of pleasure to our visit here, this Saratoga of Nova Scotia; and more so on account of the fact that we expected to meet with some of our professional brethren from across the border, and we realized that not only as a society, but individually, the result of such meeting would be a lasting benefit to us. I refer particularly to our meeting with Doctor C. E. Simon, of Baltimore, and I know that when we leave Chester to-day, we will all feel that our having met him has been of great advantage to every member of this society. I am glad to think that Doctor Simon thinks so much of Nova Scotia, so much of Lunenburg County and particularly so much of Chester, and I trust and hope that this so-called "special meeting," and our first meeting in Chester, is but the beginning of a long series of annual midsummer meets in Chester.

As to the other members of the profession who are strangers to our society, let me as president say that we are all very glad to meet with you, and hope we shall all have the pleasure of meeting you again. To the local committee and those who have entertained us today, I may say I am sure that the members of this society will all carry away with them pleasant professional and social recollections of this our first midsummer meeting in Chester.

Gentlemen, I believe it is the custom, perhaps not the duty, of the president of a medical society, to make a resume of important professional events since the last meeting. Our Nova Scotia Medical and our Maritime Medical Associations had to record the death of an honored member of the profession since their last meeting in 1902. But no such duty as this, I am glad to say, will fall to me. The only thing of importance since our last meeting, has been the death of Pope Leo XIII, and I know that we all read the accounts of his wonderful struggle for life with a great deal of interest, the treatment accorded him by eminent members of the profession etc., etc., all of which proves to me, that altho' the physician cannot save life, the means he employ tends to prolong life. One thing which particularly pleased me was that the treatment

accorded the distinguished patient in scientific Italy, was, I am safe in saying, the treatment which would have been given in a similar case by any member of the profession in Nova Scotia, and tends to prove the universality of treatment in our profession. Who among us hesitates to perform paracentesis in pleurisy with effusion where symptoms demand it?

Gentlemen, if I remember correctly the subject of our last Presidential address was "Some benefits to be derived from the existence of a local Medical Society". I do not think that I can do better than follow up that theme for a few minutes in reference to a few things which I think we as a society are in a position to deal with. First of all, gentlemen, I cannot allow this opportunity to go by without expressing regret at the action of the Quebec Legislature, in the defeat of the bill providing for a Canadian Medical Council, as introduced by our respected countryman, Dr. Roddick of Montreal, and we as a society can place ourselves on record by expressing regret at the defeat of said bill. In the words of the president of the Nova Scotia Medical Society, "that it is regretable that any parochial or exclusive sentiment in any one province should defeat and overthrow a bill, which in its province was calculated to be of great national benefit and importance."

Secondly.--Gentlemen, let me speak very briefly of a County Hospital. (a) Our needs for it, (b) the benefits to be derived from it, and (c) how to my mind the proposition can be carried through to a successful issue. As to our needs of a hospital.

It is the experience of every medical practitioner not only in this county but elsewhere, that there are constantly cases turning up in his practice which are more suitable for hospital treatment, including nursing, etc., than for private treatment.

Our resources in the past in such cases, at least so far as I am concerned, and I know that it is the case with my confreres, has been to send such cases to the Victoria General hospital for treatment, etc., an institution which in years gone by has done admirable work and was a credit to the province. I don't know why it is, but whereas in the past I had no hesitation in recommending my patients to go to the hospital, I do so now with a great deal of hesitation, for the reason that so many of my patients during the past year have returned and complained of the treatment accorded them. I do not know, gentlemen whether it is the experience of other medical men in other

parts of the province, with their patients, or whether I have a class harder to please than other medical men, but the fact remains that there have been a great many complaints during the past year or two about the Victoria General hospital. I know that as far as this county is concerned that I am not the only medical man whose patients complain, for I have talked the matter over with several of my brother practitioners and their experience is about the same as mine. Let me ask what is the remedy? I think that a number of the counties in this province have already solved the problem and a number of others are preparing to do so, in providing county hospitals, centrally situated, and built in a modern manner, where every professional man in the county can send his cases, and at the same time be in a position to attend his patient, see his instructions are carried out, and, if necessary, in surgical cases operate. Pictou county supports two such hospitals. Aberdeen hospital, of New Glasgow, is a typical county hospital, modern in every detail, a credit to the town of New Glasgow, and an ornament to those who were instrumental in bringing about its erection. It has done splendid work and has become so popular and well patronized that they are about erecting a large wing in order to accommodate more patients. Pictou Cottage hospital is another creditable institution, though on a much smaller scale than the Aberdeen hospital. It is doing a good work and has until recently been supported almost exclusively by private subscriptions, but I understand they are about enlarging it, and hope to obtain some government aid. Cumberland county has another such hospital, so has Cape Breton, and now Hants and Colchester are rapidly falling in line in the erection of a small but modern and up to date hospital. I simply mention these facts, gentlemen, to try and impress upon you that Lunenburg county needs and can support a county hospital, and why should we not have one? The benefits to be derived from such a hospital I claim are many, not only to the poor and suffering and afflicted, but to those who are enjoying good health, and last but not least to the medical profession in this county. To the poor and afflicted in that they receive careful nursing, etc., etc., which a great many do not receive in their homes. To those enjoying good health in the fact that they know that those less fortunate than themselves are made as comfortable as possible under trying circumstances, and to the medical profession in that we see our patients in a great many cases under more hygienic surroundings, and receiving more careful nursing and care

than they would get at their homes, and thus increasing our percentage of cures and lessoning our death rate. Also in making us better practitioners ,supplying a stimulus for us to exert ourselves, tending to keep us modern and up to date. It has been well said that where a county hospital exists there will be found some good surgeons.

As to the carrying through of the proposition to a successful issue, I would suggest that if the society sees fit after considering the matter in the interim, that at our next meeting a committee be appointed to consider ways and means whereby a county hospital could be erected. We have wealthy men and women in this county, whom I am sure would contribute largely to such a worthy object were the matter placed before them in the proper light. Their contributions assisted by a liberal canvass and government aid, I am sure would be sufficient to carry through the erection of a hospital which would be a credit to our county, a great help to our poor and needy, an honor to our profession in this county, and an object worthy of support by all classes..

Another matter, gentlemen, and one of vital importance, one which I think should engage our immediate attention, and one which I claim we as a society can handle with more success than as individual practitioners, is the matter of tuberculosis.

First, what can we do more than what we have done for those unfortunate fellow sufferers who are now infected? And, second, what can we do to lessen the spread of this dread disease in our several communities? Gentlemen if there is one thing which sends a thrill through me it is to diagnose a case of incipient tuberculosis and feel the inefficient means at our disposal for treatment, and this is not my experience alone but it must be that of every active practitioner in this county, for in my estimation tuberculosis in its many forms is very prevalent.

First,what can we do more than we have done for those now infected? In answer to this let me cite a typical case. A young man or young woman in our practice consults us. The complaints, family history, etc., all point strongly to incipient pulmonary tuberculosis. We make a physical examination, we may still be in doubt; we watch our case; if possible, just as early as we can, we examine the sputum, and our suspicions are confirmed. What do we do? We advise change of occupation, perhaps rest, out-door life, tonics and the ordinary routine treatment for such a case. What is the result?

If patient has been working steadily, in unhygienic surroundings, the rest, out-door life, tonics, etc., etc., particularly in summer, have a good effect and our patient seems to improve. Soon however the climatic conditions change, our patient, contrary to orders in many cases, remains in-doors, appetite fails again, commences to loose flesh and we find our patient going down hill fairly rapidly, so fast that all hope of improvement is practically gone. We content ourselves as medical men with the expression so common among the laity; "the doctor did all he could." That, gentlemen, is perhaps right. I hope it is in all cases. But we as a medical society I claim can do more for those afflicted. We can censure and justly censure our local government for the dilatory, slipshod manner in which it has dealt with the matter of a sanitarium But you say to me, supposing we had a provincial sanitarium we could not send all cases there. I say no, decidedly not, but each county could send some cases. Supposing each doctor in actual practice could send one patient every year, I am sure that some would be benefited and some cured. They would return to our county and into that individual doctor's practice, and as a result they would educate those similiarly affected in the treatment they received at the sanitarium, and as a result when a physician ordered his patient to stay out of doors so many hours in twenty four, take a tepid bath in the morning and sleep with his window open, his orders would be carried out and not countermanded by some busy-body with the local reputation of being half a doctor in that neighbourhood, as so often happens to be the case.

Another good effect that the return of a patient from a sanitarium where he or she had made marked improvement, would be the mental effect that such a patient would have upon the unfortunate ones with whom he came in contact. One of the rules of my life is to try and not deceive a patient, particularly a tubercular patient. I think it is wise that they should know at the very outset, the minute a diagnosis is made, that they are infected, for various reasons, but at the same time I always try and convince my patient that cases of tuberculosis are constantly being cured. We all know how prevalent and how wide-spread is the opinion among the laity that if you have tuberculosis you are as good as dead. This is, as we all know, incorrect, and very unfortunate, as it interferes with the successful treatment of any case.

Secondly, and in my estimation, by the far the most important is the question, what can we do to lessen the spread of this dread disease in our communities? I claim, gentlemen, that this society can do much. As medical men we all recognize the infectious nature of the tubercle bacillus. As a society how can we impress this important fact upon the public? And after having succeeded in impressing this fact upon them, how can we educate them to live in such a manner as to lessen the possibility of infection? In answer I say that if we succeed in having them thoroughly destroy the sputum of infected persons, I think we have succeeded in a great measure. After explaining to a patient and the members of the household the highly infectious nature of the sputum, I either supply them with a sputum cup and card board container, procurable at all of our drug stores, or else advise and see that they procure a roll of ordinary toilet paper, tear off a portion when they want to expectorate, fold it and place it in a covered pasteboard box, and burn contents of box night and morning. But how often after giving vigorous instructions concerning these matters have we all seen our orders disobeyed. The patient, and very often the friends, do not believe there is any harm in spitting out of doors or in spittoons, etc., and persist in doing so. This is why I claim, gentlemen, educating the public to believe that the sputum is infectious is of great importance. How can this condition of affairs be remedied? I would suggest that a committee of medical men from this society, wait upon our municipal council at its next session, and show them the necessity of some action being taken in regard to the matter of tuberculosis. Urge upon them the necessity of granting a sum of money for this purpose, and instead of a health officer for the whole county being appointed, let a local health officer be appointed for every district, to whom the other physicians in that neighbourhood can report, and let it be the duty of the local health officer to supply to the other medical men in his neighbourhood a set of printed rules, endorsed by our society, also sputum cup, etc., and when a case is reported, the rules in regard to the destruction of the sputum can be supplied to the house, and if people are poor and needy let sputum cup, container, etc., be supplied. Let the local health officer keep an account of cases reported by the individual medical men as they develop, and in this manner a record of statistics as regards to tuberculosis can be kept, and our progress in combatting the disease noted from year to year. In the case of

incorporated towns, let the medical men practicing in those towns report to the health officer in the towns, and let that officer keep an account of cases reported. This in conjunction with respective local health officers should give us a fair estimate.

Finally, gentlemen, let it be the duty of the health officers to see that all houses are properly fumigated after consumptives have left. If owner of house refuses to pay, then let the officers do this and charge owner with same, or let sufficient monies be granted by the council to pay for this.

In conclusion, gentlemen, let me ask that every member of this society consider this matter of tuberculosis seriously.

What greater monument could be erected to our memories than that the charter members of the Lunenburg Medical Society were instrumental in reducing the mortality from tuberculosis in the country to a marked degree? This I claim can be done if we as a society work unitedly and harmoniously.

THE EYE IN ITS RELATION TO GENERAL DISEASES.*

By A. Pierce Crockett, M. D., St. John, N. B.

There is no part of the human anatomy which throws so much light upon constitutional derangements as the eye, and to it we are often called upon to look for information in making a diagnosis of general diseases.

This is not to be wondered at, considering the admirable opportunity the fundus of the eye affords us for watching the circulation of life's fluid through the smaller ramifications of its wonderful system and in seeing the actual conditions which exist in that system. Here are first depicted the very first evidences of so many constitutional diseases. Here, sclerosis, with its disastrous results, first exhibits itself in the thickening of the vessels. Here, too, various nervous affections first manifest themselves. And not only in the fundus, but in other parts of the eye, are often exhibited a brain of symptoms which give us a diagnosis, and enable us to scientifically treat the true condition.

Of the nervous affections that of locomotor ataxia (tabes dorsalis) first suggests itself chiefly because of the great frequency with which the eye is so early involved in this affection. The very first symptom may be ptosis or diplopia with external strabismus. Occasionally we find paralysis of all the external ocular muscles. The pupils usually are markedly contracted, and the iris-reflex to light abolished while the iris-reflex to accomodation is still present. Dimness of vision may also be the very first symptom complained of, and here a view of the optic disc with its pallor tells the story of commencing atrophy which so often leads to blindness.

The antagonism which exists between the ocular symptoms and the ataxia is a valuable aid in our prognosis, from the fact that when the atrophy develops early and leads to blindness, the ataxia rarely, if ever, comes on.

The opposite condition, viz. optic neuritis, first suggests some form of brain tumor, and in the great majority of cases this is dependent

*Read before the St. John Medical Society.

upon some constitutional condition, usually syphilis. The congestion and swelling of the disc in these cases is not a true inflammation, but more of an inflammatory œdema. Any increase in the intracranial pressure, the skull being unyielding, is felt along the courses of least resistance, which are the spinal cord and the optic nerve. The spaces between the sheaths of the optic nerve are dilated by the increase of cerebro-spinal fluid, and this causing a stasis of the lymph in the nerve itself, especially in the region of the lamina cribrosa, which is the mesh-like portion of the sclera through which the fibres of the optic nerve enter the eye, produces œdema. The pressure of this œdema naturally is first felt by the less resistant vessels. The central vein is so compressed as to impede the circulation in it. The central artery is also compressed, but to a less degree, and it continues to pour into the papilla blood which cannot be carried away by the compressed central vein. We have thus a veinous engorgement and swelling of the optic nerve, and this is a most important symptom of increase of cerebral pressure, particularly where the papillitis is of an intense kind (choked disc). The paralysis of the various ocular muscles in these cases is a most valuable aid in the localization of the tumor.

Other constitutional conditions producing optic neuritis are acute infectious febrile diseases, acute anæmia, and orbital affections, the latter producing symptoms in one eye only.

Heredity plays a part in the above affection, for we find members of certain families attacked with neuritis in whom no special cause can be discovered, and, strange to say, it is the male members who are usually affected, and about the twentieth year of age.

Hydrocephalus, exposure to cold, suppression of menstruation, and lead poisoning are other causes which may give rise to optic neuritis.

Chronic retrobulbar neuritis(toxic amblyopia), a much more frequent affection than is generally supposed, may, I think, be classed as a general condition presenting the most prominent symptoms in the eye, and it is to this organ we look for a diagnosis of the condition.

The patient first notices a dimness of vision, more marked in a bright sunlight; his perception for certain colours fails him; and he is unable to recognise a small red or green object near the point of fixation. Later a small white object will not be seen in this region nor even a small candle flame.

Dyspepsia and loss of appetite are constant symptoms, and trembling

of the hands or head. Sleeplessness or even delirium may be present.

The relationship between the two chief affections of the urinary organs, viz. albuminuria and diabetes, and the eye seems to be better understood in the former affection than in the latter. In chronic nephritis we are dealing with a degenerated condition of the arterial system, and these changes are sufficient to account for all the pathological conditions produced in the eye in this affection. This is not the case in diabetes, which produces many more ocular symptoms. The sugar theory does not explain the production of diabetic cataract or the paralysis of the various ocular muscles, nor will it explain the various changes in the fundus of the eye in this affection, for if, so, we would expect to find these conditions in temporary toxic and traumatic glycosuria when we so often have such large quantities of sugar present in the urine.

Again, we have large quantities of albumin excreted in acute nephritis and in albuminuria of pregnancy and yet the ocular symptoms not often accompany these conditions, but we do find them very often accompanying chronic nephritis, particularly that form with contracted kidneys and sclerosed vessels. This would lead us to believe that sclerosis, if not the chief cause, plays a most important part in the production of the various ocular manifestations in this affection.

In diabetes we look to the nervous system for an explanation, some day, of the conditions produced in the eye. In both these affections the ocular symptoms are often late in making their appearance, yet they frequently are the result of a diagnosis of the true condition being made.

In albuminuria a temporary œdema of the eyelids often first attracts the attention of the patient. Later on the various ocular conditions may supervene. The patient notices a dimness of vision, and ophthalmic examination shows a congestion of the papilla with numerous flame-shaped hemorrhages in the region of its border The retinal arteries are small, and the veins are dilated and tortuous. Here and there scattered about the fundus are a number of whitish patches, the result of fatty degeneration of the outer layers of the retina, and surrounding the macula a group of small white specks combining to form a stellate figure characteristic of albuminuric retinitis. These dots are the result of fatty degeneration of the inner ends of Muller's fibres. The vitreous may or may not contain clotted

blood, the result of hemorrhages. Complete blindness in these cases is rare, although the vision is usually seriously interfered with. In albuminuria of pregnancy and in uræmia, on the other hand, we do get complete blindness coming on suddenly, with complete restoration of the vision later if the patient survives the attack. In these cases the fundus will usually be found normal. In the neuro-retinitis of albuminuria of pregnancy with threatened loss of vision we should not hesitate to induce premature labor.

In albuminuric retinitis the prognosis as regards life is bad, the great majority dying within eighteen months of the first appearance of the retinal affection. Life, in many cases, can, however, be prolonged by the proper hygienic treatment and suitable diet, which few, unfortunately, will carry out.

The fundus in diabetes somewhat resembles the fundus in albuminuria. The brilliant white spots, however, while in the region of the macula, as in albuminuria, do not present that stellate arrangement so characteristic of albuminuria. Sometimes one or two large white patches are seen, the crenated borders of which show that they are made up of a number of smaller ones. Between the white patches are punctate extravasations of blood. The rest of the retina is transparent, the vessels and disc normal.

While the above fundi are characteristic of albuminuria and diabetes, we do get fundi in these affections which are not characteristic of either, thus showing the importance in all cases of retinitis for examination of the urine.

There is no part of the eye which is exempt from the invasion of syphilis, although the uveal tract is the part usually affected, doubtless on account of its great vascularity. As the eye depends chiefly upon the uveal tract for its nourishment, it is natural to suppose that any condition which seriously affects this tract must secondarily be felt in the parts supplied thereby. While it is chiefly the secondary manifestations of the disease we see in the eye, we also see the primary and tertiary. Occasionally the initial lesion appears upon the eyelid, or even upon the bulbar conjunctiva or caruncle. The secondary manifestations usually appear in from six weeks to ten or twelve months after the initial lesion, and are usually first noticed as a plastic iritis. The clouding of the aqueous and vitreous, the result of increased hyperæmia and consequent transudation, often prevents an ophthalmoscopic view of the fundus, but when these have part-

ially cleared away, we see a damaged choroid with its numerous perforations showing the sclera in the background, and the heaped-up pigment limiting the size of the opening, with or without various pigment spots scattered about the fundus, the retinal vessels passing over them. In some cases we get an almost complete atrophy of the pigment-epithelium layer which exposes to view the vascular network of the choroid.

The retina being so closely associated with the choroid joins in the inflammatory process, being followed by the vitreous, which, in cases due to syphilis, often presents a fine dust like opacity which is held by many writers to be pathognomonic of that affection.

A dull orange colored nodule in the iris is of diagnostic importance in regard to its position. When it occupies the lower pupillary border it is strong evidence of its syphilitic nature, while its position in the iris, at the angle of the anterior chamber, and lighter or grayish colour, suggests a tubercular origin. Iritis often leaves evidence of its former presence in posterior synechiæ.

In congenital syphilis the most frequent affection of the eye is interstitial keratitis, although we do occasionally find other of the above mentioned conditions. Interstitial keratitis usually commences between the ages of five and fifteen, and in over 50 per cent of the cases is due to inherited syphilis, exhibiting that peculiarity of the incisor teeth pointed out by Jonathan Hutchinson.

The children are often thin, anæmic and of stunted growth, with cicatrices at the angles of the mouth, and often have deficient hearing.

Scleritis is another eye affection caused by syphilis.

As regards the treatment of these syphilitic affections of the eye, unfortunately they will not all yield to anti-syphilitic treatment, and it may be laid down as a general rule that the earlier they come under treatment the better is the prognosis. In old standing choroido-retinitis of syphilitic orgin (for these two affections are usually associated) very little can be done, although they seldom lead to actual blindness. We must not think because some of these eye affections yield to anti-syphilitic treatment that they are necessarily of syphilitic origin, for the anti-syphilitic remedies often have an alterative affect which is most beneficial. The diagnosis between this affection and that of tuberculosis is often arrived at through the ocular manifestations present. As is well known, a great similarity in the symptoms of pneumonia, typhoid and meningitis often renders a

diagnosis very difficult, and in some cases impossible without the use of the ophthalmoscope. A view of the fundus will, in many cases, exclude or diagnose meningitis. The disc may be hyperæmic or a well developed papillitis may exist.

The miliary tubercles in the choroid in acute tubercular meningitis are also a valuable aid in our diagnosis, as is also the involvement of the different ocular muscles, associated with or without diplopia.

As in typhoid, ulcerative endocarditis, puerperal fever and scarlatina, a septic choroiditis may develop in the early stages of meningitis.

Of the rheumatic affections of the eye, iritis and scleritis are the most common. In phlyctenula of the conjunctiva and cornea, as well as herpes, we have conditions allied to eczema. Indeed, the Germans have very properly named the two former affections "conjunctivitis und keratitis eczematosa," respectively. Associated with either of these conditions we usually get an eczematous condition at the entrance to the nose, and less frequently similar conditions about the face. Tubercular and strumous children are more prone to these affections, and in such cases we must look well to the hygienic and constitutional treatment as well as the local. In all cases examine for refractive errors and correct them, if present.

In Basedow's disease (exophthalmic goiter) it is the position of the eye and the lid symptoms, rather than the eye itself, which call for attention. The eyes are normal, except late in the disease, when, as the result of the high exophthalmos, the lids are unable to approximate and protect the cornea, which becomes dry and insenitive, and keratitis develops. The inability of the upper eyelids to follow the downward motion of the eyeballs is an important and early symptom, not altogether pathognomonic, but quite often one of the earlier symptoms, and nearly always present before the exophthalmos. Winking also is less frequent in this affection than normally. The exophthalmos is due to the hyperæmia of the retrobulbar orbital tissue. When keratitis develops, bandaging of the eyes, or even the permanent closure of the outer portion of the palpebral fissure, is called for.

Of the infectious diseases, erysipelas of the face may extend to the lids, producing œdema, abscess and necrosis, with conjunctivitis.

Dacryocystitis may be the result of erysipelas and later produce a

conjunctivitis. In all cases of conjunctivitis an examination of the lacrymal sac should not be neglected, for here is often found the cause of the trouble in a purulent condition of the sac.

A few cases of marked improvement in trachoma, in which erysipelas has supervened, have been recorded.

Measles, in the prodromal stage, is often accompanied by conjunctivitis, photophobia and lacrymation; and for some time after the disease has disappeared, marginal blepharitis, phlyctenular conjunctivitis and keratitis with weakness of accommodation and asthenopic symptoms continue to annoy the patient. These are more apt to occur in those who have hypermetropia or astigmatism, and oftentimes will not yield to treatment until these refractive errors are corrected.

Similar conditions exist in scarlatina, but not so frequently as in the above affection.

In diphtheria the most important ocular manifestation is paralysis of accommodation, coming on a fortnight or so after apparent recovery. This may last for months, but is much more amenable to treatment if any refractive error has been properly corrected.

Diphtheritic and croupous conjunctivitis are rare complications.

Conjunctival and corneal complications in smallpox are now not so frequent nor as serious as before the introduction of vaccination.

THE MICROSCOPE AS A FACTOR IN DIAGNOSIS AND PROGNOSIS.*

By J. M. Barry, M. D., St. John, N. B.

I wish to plead tonight for the more general use of the microscope in medicine. I know that I will be met at the outset with the argument that the cost of the instrument places it beyond the reach of many; that its use requires a special training; that it requires more time than the busy practitioner can afford; and besides that, it is not practicable to bring it into general use. I grant all these things to a certain extent, but I do claim that its value as an aid to us in our daily work will more than counteract at least some of these disadvantages.

I propose to detail a few of the indications for its use besides one or two cases from personal observation which proved its great value in diagnosis.

It is in the hospital work of course that its advantages are most manifest. But in general practice, too, it seems to me that it might be employed with profit more frequently than it is

I do not wish it understood that I would have the practitioner carry a microscope with him on his daily rounds as he carries his thermometer or his stethescope, but there are times when it would be a distinct advantage to have that instrument with him—though those occasions are rare. Diagnosis is not always easy, diseases and pathological changes are not labelled, and in the solution of a difficult case any aid or any method would be more than welcomed.

It is not my intention to speak of the microscope in its connection with bacteriology. Every day we utilize it in that department of medicine; it is not in that quarter that its use is neglected. Neither shall I have much to say of its use in general pathology. I shall confine myself principally to its value in a study of the blood.

Until the discovery of the plasmodium of malaria and its recognition as the causative agent in the production of that disease, diagnosis between typhoid and certain forms of malarial fever was frequently

*Read before the St. John Medical Society, October, 21st, 1903.

very difficult and sometimes impossible. There was a well grounded opinion in some quarters that a connection or similarity existed between the two diseases. Hence the name typho-malarial fever. And the patients suffering from either disease were dosed with quinine. Now, thanks to the microscope, the malarial patient gets his quinine in stiff doses, and the typhoid patient his cold bath with little or no quinine. The fact that we have little or no malaria in this country is of no importance. No one knows when he may meet a case—and possibly treat it for typhoid. In connection with the diagnosis of malaria from other diseased conditions, I might relate an incident which came under my observation, and which clearly demonstrated the value of an examination of the blood. A woman was sent to the Baltimore City hospital for operation for some kidney trouble. The idea of the attending physician was, I think, that she was suffering from pyelo-nephritis—and certainly she had some symptoms pointing to that disorder. She had occasional rigors and irregular fever, and pain in the region of the kidney radiating towards the groin. Some pus was also present in the urine. As a matter of routine, her blood was examined and the malarial organism demonstrated. She was placed on large doses of quinine, and the symptoms promptly abated. The pus, the presence of which I cannot explain, also disappeared from her urine.

In determining the progress of an appendicial process, an examination of the blood plays an important role. As is known, leucocytosis exists in this disease as in all suppurative processes. An occasional leucocyte count will clearly demonstrate to the surgeon whether the process is advancing or receding, an increase in the white cells indicating an increase in the severity of the disease and *vice versa*. This would be a case where it would be well to carry the microscope along with you, and use it at the bedside.

There are cases, too, when a definite diagnosis between typhoid and appendicitis would save the physician some anxious moments. A blood examination would be of great assistance. There is no leucocytosis in typhoid. And that reminds me of another point. If, during the course of a case of typhoid, a leucocytosis develops, what does it mean? It means that suppuration exists and that perforation has probably taken place. Of course in a case like this, an intercurrent disease, such as pneumonia, should be excluded, and the newly developed symptoms, if any, should point to perforation.

In pneumonia a careful examination of the blood is a valuable aid in prognosis. A reasonable leucocytosis—12000 to 15000 per c.mm.—is the rule in an ordinary case. A great increase, say from 40,000 to 60,000 to the cubic millimetre, or an entire absence of leucocytes, would indicate a profound toxæmia and a correspondingly grave prognosis.

In the different anæmias and leukæmias a frequent examination of blood is necessary in both diagnosis and prognosis. It is possible to mistake chlorosis for pernicious anæmia. And what a vast difference there is in the prognosis in the two diseases. I have been much impressed during the past two years with the large number of deaths reported to the board of health of this district as occurring from pernicious anæmia—not a very common disease. I wonder in how many of these cases was a diagnosis made after an examination of the blood; and yet how difficult it must be to otherwise diagnose this disease.

Certain cases of trichiniasis closely simulate typhoid fever. A study of the blood revealing a great increase in the eosinophiles would be strongly suggestive of trichiniasis, and would exclude typhoid.

It may seem strange that abscess of the liver should be mistaken for diabetes. A patient came to the hospital said to be suffering from diabetes and had been treated for such by his family physician. It was certainly an obscure case; the symptoms were not very definite. His urine responded to the usual tests which depend on the reduction of the metallic substances by the glucose, but when the fermentation test was tried it proved negative. Diabetes had to be excluded. The blood showed a slight leucocytosis. The patient was carefully examined and abscess of the liver was diagnosed. The abscess was opened and drained and the patient made a good recovery. Strange to say that the substances in the urine which reduced the copper, bismuth, etc., disappeared.

I have merely jotted down a few thoughts as they occurred to me. Very much more might be said on the subject. I do not pretend to have covered the ground as it should be covered, but probably I have said sufficient to invite a discussion on this most important and interesting subject—the microscopical study of the blood.

Selected Article.

SUGGESTIONS ON THE NATURE AND TREATMENT OF DELIRIUM TREMENS.*

By James F. Kelly, M. D., Cleveland, First Assistant Physician, Cleveland State Hospital.

During the past five years I have had quite an excellent opportunity for observing a number of patients belonging to the class of alcohol habitues, who have from time to time been admitted and readmitted to the State Hospital at Cleveland. These observations have made more clear to my mind the true outlines of certain phases of alcoholism and, I hope, likewise extended my knowledge of their rational treatment. In this paper it is chiefly my object to call attention to the significance of the so-called prodromata or what might be more appropriately termed the first stage of delirium tremens; the second stage, or period of true delirium, being in my opinion a culmination, often needless, of the first. I mean by this that when the patient can be treated from the beginning, prophylaxis is not only of the greatest importance, but, judging from my experience, comparatively simple.

Delirium tremens, commonly so termed, is invariably associated with alcoholism; that is, alcoholic habituation always exists before delirium tremens occurs. In the light of our present knowledge a satisfactory definition of the term "habituation" as applied to any drug cannot be given. We may, however, safely assume that the alcoholic habituation indicates a semipermanent and abnormal change in the central nervous system involving very markedly certain elements of the will; that it signifies the existence of a morbid appetite based upon a distinct pathology, and I am convinced that *under certain conditions* the demands of this appetite constitute an actual necessity which cannot be unheeded without severe suffering, and in

*Read at the meeting of the Association of Assistant Physicians of the Ohio State Hospitals, October 7, 1903.

some instances, danger to health or life. On the other hand, an alcohol habitué may live his life and finally die without having had delirium tremens. Why this may be and what, I am inclined to regard as the real nature, and a determining or immediate cause of this psychosis will be stated later.

For certain reasons I would divide delirium tremens into two stages: The first stage, the one during which the consciousness is not materially altered, and the second stage as that which is signalized by a distinct alteration continuing until either convalescence or death. In order to further emphasize the point, as it were, at which the first stage ends and the second begins, I shall hastily allude to the more prominent symptoms. During the first stage there are pallor anorexia, tremor and muscular weakness, general hyperexcitability, restlessness, fear, sleeplessness, and usually albuminuria. Among the various psychic phenomena attending this stage, the exaggeration of the emotion of fear is perhaps the most striking. No other very remarkable mental manifestations occur as yet. The patient craves alcohol and repeatedly asks for it. This stage continues for several hours or longer. Under certain conditions these symptoms gradually become more prominent and finally merge into the second stage. This stage, with alteration of consciousness, is heralded by the advent of hallucinations and illusions, always disagreeable and usually horrifying. Upon these disorders of sense are based fleeting delusions of fear and suspicion. The patient now will often refuse water, food, or medicine. He is watchful, apprehensive and depressed. His mind is dominated by thoughts of escape from the imaginary dangers which beset him. He occupies much of the time looking or groping about the room, restlessly examining keyholes, crevices and walls. He may feel justified in jumping out of a window, breaking a door, committing homicide or suicide. The earlier objective symptoms still persist and are more alarming. The pulse is rapid, soft and of poor tone, the skin is moist, the bowels and kidneys are inactive, the tongue is dry, the pupils are dilated, and sleeplessness continues. Usually after a week or ten days convalescence begins. Death very frequently ensues from exhaustion and coma.

An interesting phenomenon which I have observed after the seconp

stage was established has been a changed mental attitude toward alcohol. Frequently patients no longer have a conscious craving for the drug, and in several instances they have even refused to accept it. Also in the cases I have seen, whether traumatism had been sustained or not, the physical symptoms *en masse* have always seemed to indicate the presence of more or less shock.

It is hardly necessary to say that alcoholic habituation is the basic factor in the etiology of delirium tremens, and that, together with this, there is nearly always a history of unusually heavy dissipation shortly prior to an attack. There is still, however, in my opinion, another more immediate or determining factor which seems to have attracted little notice, but which I believe to be constant and of great importance, namely, sudden abstention or, in other words, sudden withdrawal of alcohol either wholly or in large part as the result of poverty, accident, force, or insane wilfulness.

Influencing unfavorably the effect of such abstention are first shock and, second, unusual physical or mental depression from whatever cause. The seriousness of the condition following sudden abstention is also modified by the degree to which organic habituation exists, the extent to which recent unusual dissipation has occurred and the patient's innate vitality. It is therefore true that in certain favorable cases sudden abstinence apparently does not entail serious consequences. On the other hand, as illustrative of what I regard as the usual effect of sudden abstinence under certain conditions, the following is given: An alcohol habitué meets with an accident. Suffering from shock and helpless, he is unable to obtain the drug which now, more than ever, his organism demands. He is conveyed to his home or possibly to a hospital. The physician notices at once among other things the evidences of alcoholic excess. Although the patient pleads for alcohol, little or none is given. It is reasoned that as the prolonged and excessive use of alcohol has already seriously injured the patient's health, and has been the chief cause of his present unhappy plight, alcohol, above all other things, should be removed, and the sooner it is done the better. The important factors of habituation and sudden abstention are apparently disregarded even though the patient is already manifesting tremor, fear, and other prodromal symptoms of like significance. Chloral, the bromids, etc., are largely

relied upon; and if alcohol is given at all, the amouut is so small as to be of practically no benefit, in spite of there being two strong indications for its administration in large amounts, viz., alcoholic habituation of the patient and the presence of shock. We know how frequently and, I might add, unnecessarily, the culminating phases of delirium tremens develop under these circumstances, and that the following results are usually unsatisfactory: That alcohol in such a case is the poison fundamentally responsible for the patient's condition, and that it should be removed goes without saying. Yes, but it should be removed in the proper manner, *i. e.* gradually, not abruptly.

When a comparatively normal person unwisely or wrongfully indulges in alcohol to the extent of intoxication there follows certain sequels which may be disagreeable and even serious. Such have not, however, either in their nature or character, any semblance to the manifestations of delirium tremens. The alcohol habitué is by no means normal either mentally or physically, and I would think it no less illogic to expect similarity in the sequels, as for instance, malaise, constipation and headache following several large doses of morphin taken by a normal being, to the abstention psychosis with vomiting, diarrhea and collapse resulting from sudden deprivation in the case of a morphin habitué.

Is then delirium tremens an alcohol abstention psychosis? In a spirit of inquiry rather than of assertion, I would say that it is. In other words, I am much inclined to believe that abrupt withdrawal of alcohol either wholly or in large part after habituation has been established is the principal determining cause of delirium tremens. This opinion is based chiefly upon the results of two plans of treatment both of which I have employed, viz., sudden withholdance, and gradual withholdance. The former plan which is still advised by writers of authority was in vogue at St. Alexis Hospital while I was a resident there in 1896, and in my practice at the State Hospital until about three years ago. With the former method I not infrequently have seen delirium tremens develop in cases under my charge, while during the past three years since practicing gradual withholdance none have occurred. This is significant because of the fact that since then I have come in contact with more cases of this

class than during the two previous years. For instance, we have a certain alcoholic patient who has left and returned to the hospital upon four different occasions. Always upon his return he has shown marked evidences of recent alcoholic dissipation. During 1900 he was returned twice. Alcohol was prohibited from the beginning. He developed delirium tremens each time. During 1902 he was returned twice in a condition which, if anything, was more serious than ever before. Upon these occasions alcohol was given in proper amounts and gradually reduced to nil in about a week. Delirium tremens did not occur.

There is evidently a remarkable difference of opinion among authors who have laid down rules for the treatment of this disorder. For example, Osler and Berkley, on the one hand, state respectively that "alcohol should be withdrawan at once unless the pulse is feeble" and that "alcohol in all forms should be absolutely prohibited from the onset of the treatment unless there is a marked tendency to heart weakness and collapse." On the other hand the American Text-Book of Surgery says: "The prophylactic treatment consists in the employment of alcoholic stimulants in moderate quantities of capsicum and digitalis, and of nourishing food"; and that, "during the attack mild stimulation with liquor or beer is usually advisable."

As regards the statements of Osler and Berkley, I think it can hardly be gainsaid that in all cases of delirium tremens there is from the very beginning a decided depression of the circulatory system characterized by the feeble pulse and other evidences of such depression; and also that unless there is an organic circulatory *lesion*, the degree of feebleness of pulse and tendency to heart weakness is always in direct ratio to the severity of the disease. The advice in the American Text-Book is, it seems to me, much more to the point.

It has been my experience that the symptoms characterizing what has been termed the first stage have invariably disappeared when alcoholic stimulants were given in sufficient quantity. I refer particularly to the tremor, fear and loss of appetite. Ordinarily an ounce of whisky or brandy with half a pint of water is given every two or three hours, the amount being varied of course in accordance with the severity of the symptoms and gradually decreased. The doses should be large enough to control the symptoms and no larger.

When it is learned what amount of alcohol will do this, and the patient begins to eat, diminution should be commenced and continued as rapidly as the condition will permit. The doses can usually be decreased to nil in less than a week. If shock from traumatism, exposure or other cause, is present, more alcohol is required than if this complication were absent. If the culminating phases of the disorder have developed before the patient is seen, the outlook is of course not so good, but alcohol is beneficial if the patient will accept it. If he should not, then other remedies must be relied upon. With the return of appetite and ability to retain food the patient should be given as much light nourishment every two or three hours during the day as he can apparently assimilate. Other remedies of value are warm baths, plenty of light and ventilation, and moderate exercise. I think that nux vomica, capsicum and the bromids are indicated at times. I have seen no good result in these cases from the use of either chloral or morphin, and I am even inclined to regard their use as injurious.—*The Cleveland Medical Journal.*

THE
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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Editorial.

REPORTS ON PUBLIC CHARITIES, NOVA SCOTIA, 1903.

THIRTY-SEVENTH ANNUAL REPORT OF THE VICTORIA GENERAL HOSPITAL; FORTY-SIXTH REPORT OF THE NOVA SCOTIA HOSPITAL; ELEVENTH ANNUAL REPORT OF THE PROVINCIAL BOARD OF HEALTH, NOVA SCOTIA.

We note with pleasure the fact that Dr. Sinclair is able to report a steady improvement in the conditions and management of our poor houses and local lunatic asylums. There is one circumstance which we are sure will tend to raise the standard of management, and that is the gradual installation of graduate nurses of the Nova Scotia Hospital as superintendents of these institutions.

The marked success of the Aberdeen Hospital at New Glasgow has encouraged the friends of local hospitals elsewhere. At Glace Bay, St. Joseph's Hospital is now completed. It can accommodate fifty patients, and is a great boon to the mining population of that rapidly growing centre. The hospital at Amherst will soon be ready for occupation and will doubtless give a good account of itself. Other towns are taking steps to erect hospitals. We think it right, however, to call attention to Dr. Sinclair's warning as to provision for the future maintenance of a hospital. He points out that each patient will cost at least $1.00 a day, and when we reflect that the maintenance of a single bed, continuously occupied for a year, would require a capital of at least $7000, we see that the labours and anxieties of hospital enthusiasts are not over when the hospital has been furnished and opened to the public.

There are two or three points to which we would like to refer in connection with the Victoria General Hospital. As in most general hospitals admission is refused to cases considered incurable. This is perfectly right, for it is evident that were it otherwise the hospital would, in a few years, be occupied entirely by incurables, and its primary purpose as a place of cure would be defeated. The evident corollary is that we should have a Home for Incurables.

In a Christian country the great majority of those who suffer from incurable disease are tended carefully and kindly by their relatives. But in any community there may be some unhappy man or woman having no relatives, and without means of securing nursing. There are cases also of incurable disease in which much unnecessary pain and discomfort would be alleviated by expert nursing, which is not always available even in a well to do home.

We believe the time has come when the establishment of such an institution should be considered.

Another subject for reflection is the question of the private wards in the hospital.

We are entirely in accord with the suggestion of the superintendent that the present rate of $9.00 a week should be increased. The regular rate of pay in the public wards to those who are able to pay is $7.00 a week. It is preposterous that any one should then have all the advantages of a private ward for only $2.00 a week more. We do not forget that the patient in the public ward has his medical attendance free, while his neighbour in a private ward must pay his doctor.

But is it fair to the hospital doctor that he should have to give his services free to a man who can pay $7.00 a week for his bed and board ?

The hospital is primarily for the poor, and we are convinced that in providing private wards at $9.00 a week, the taxpayers of this province are losing money. An enquiry is at this moment being carried out in the United States as to the profit or loss of the private wards. Opinion is divided, but many aver that they do not pay. All depends of course on the rates charged. We do not believe it is possible to provide beds in a private hospital in our province for $10.00 a week, and we think the rate at the Victoria General Hospital should be raised to at least $12.00 or $15.00.

In the Report of the Medical Board of the Hospital there is a recommendation that facilities should be provided for the preservation of pathological specimens. The absence of a proper pathological museum in the hospital is nothing less than a calamity. An intelligent study of pathology is the foundation of scientific treatment. What we should like to see would be a more intimate connection between the Victoria General Hospital and the Medical School. There are obscurantists everywhere who object to the use of hospitals as schools for medicine, and some hospital authorities are too ready to second the complaints of ignorant and ungrateful patients who object to being made the subject of clinical demonstration. There may be faults on both sides, of course, but the fact is that no hospitals in the world rank so high in their practical results as places of cure as those connected with schools of medicine.

We would direct attention to the paragraph in Dr. Hattie's Report in which he deals with the increase in insanity. The actual increase in cases of insanity is little short of appalling. During the last forty years, while the population of Nova Scotia has not increased by fifty per cent. the admissions for insanity have increased by nearly two hundred and fifty per cent. We are not alone in our madness. The ratio of insane in England in the same time, say forty years, has increased from 1:536 of the general population to 1:293. In California, in 1870, the proportion was 1:500 it is now 1:260.

Everywhere the same startling statistics: the increase in the insane population is rising out of proportion to the increase of the sane. What can be the cause of this? Doubtless there are many causes, but we believe that behind all the alleged factors of stress and strain, intemperance and excitement, lie faults of education. And this leads us to the observation that the most interesting and suggestive paragraph in all these reports is the plea made by Dr Sinclair for an institution for the feeble-minded.

We commend this paragraph (p. 13, Report on Public Charities) to the careful attention of our readers, and we sincerely hope that we may soon have in these provinces such an institution as Dr. Sinclair pleads for.

We have long ago recognized the value of hospitals for diseased

bodies, and asylums for the insane are really special hospitals, for mental defect is based on some physical (cerebral) defect. But we all also recognise that prevention is better than cure. A properly conducted institution of this kind would not only be a boon to those for whom it is intended but it may confidently be expected to restore many of them to a healthy equilibrium of mind and body.

It is needless to say that the course of instruction in such an institution would be different from that in our common schools. We almost envy the lot of the feeble-minded boy. We read that "careful attention is paid to the inculcation of simple principles of morality, the teaching of correct habits and behaviour, and observance of the ordinary amenities of life," and then we reflect upon our experience of the principles and habits and "amenities" of the average young person in our schools. But we disclaim any intention of tilting against our school system as such, or giving it the whole blame of a faulty educational system. For the education of the child begins long before his earliest appearance in school. Education begins at home. It is a strange heaven that lies about some of our young people in their infancy. Many an earnest teacher knows full well how his efforts at leading his charges into a brighter, and higher and nobler plane of life are frustrated by the home influences. The parents have the custody of the child and *quis custodiet custodes*?

COMPULSORY NOTIFICATION OF BIRTHS.

The profession of the Maritime Provinces will note with much satisfaction the outcome of the attempt to impose compulsory notification of births upon the physicians of St. John. A letter published in the last issue of the NEWS gives a detailed account of the proceedings and the grounds of objection taken by the profession.

Unless the medical profession look after their own interests and protect themselves, it is quite certain that no one else will do so for them.

There is much to be done in this direction—the profession has so long allowed legislation to proceed without regard to what is common fairness and justice.

At the final meeting of practitioners held to deal with this subject

in St. John, it was decided to discuss at some future date other matters of legislation which are unsatisfactory, involving, as they do unremunerated work, such as notification of infectious diseases.

May the good work progress.

PRIZE CONTEST.

A good opportunity for some of our readers to embrace is the prize competition announced by Farbenfabriken of Elberfeld Co., 40 Stone Street, New York, in their monthly publication, "Clinical Excerpts." We here append full particulars as taken from that paper:

"The following subjects have been selected:

1. The Best Method of Administering Potassium Iodide.
2. The Indications of Ergot aside from its Obstetrical Uses.
3. The Indications for Venesection.

The above topics show conclusively that in their selection we have been absolutely uninfluenced by any desire for advertising the Bayer products. Our sole aim has been to promote a better knowledge of the indications and manner of use of the therapeutic agents mentioned, and by their publication to enhance the value of "Clinical Excerpts." This policy will be strictly maintained in future prize contests, so that the most ethical physician can have no objection to participating in them.

1. In view of the fact that the prize competition is devoted entirely to practical therapeutics and not to subjects of merely theoretical interest, the essays should be based upon the clinical experience of the author, and not upon citations from text books or upon the writings of others, and must not have appeared in print before.

2. Mere literary excellence will not be considered, but chiefly the value of the ideas and suggestions brought out.

3. The article should be written clearly and intelligibly and in sufficient detail to afford a thorough understanding of the points at issue.

4. While no exact limit is set upon the length of the papers submitted, it is requested that they do not exceed 2,000 words, and that they be written on one side of the paper only.

5. Any of the topics suggested may be selected, according to the preference or experience of the writer.

6. A special committee of three representative physicians has consented to assist us in the award of the prizes, which will insure absolute impartiality.

7. No paper should bear the name, initials or address of the author, but should be marked with some emblem or motto and accompanied by a sealed envelope containing the writer's name and address, marked on the outside with the same emblem or motto. The envelope will not be opened by us until after the sucessful essays have been selected, and the awards will then be announced.

8. The first prize competition will close May 15, 1904, by which date all papers must be in our hands.

9. We reserve for ourselves the sole right to publish any or all of the essays submitted in competition in our "Clinical Excerpts."

10. Prizes will be awarded as follows:

1. The Best Method of Administering Potassium Iodide.
   For the best essay on this subject, $200; second best, $75; third best, $25.
2. The Indications of Ergot aside from its Obstetrical Uses.
   For the the best essay on this topic $200; second best, $75; third best, $25.
3. Indications for Venesection.
   For the best essay on this subject, $200; second best, $75; third best, $25.

For the next best thirty essays, ten on each subject, there will be awarded a year's subscription for any American or foreign medical journal selected by the successful competitor."

CANADIAN MEDICAL ASSOCIATION.

The thirty-seventh annual meeting of the Canadian Medical Asoociation will be held at Vancouver, B. C., on the 23rd, 24th, 25th and 26th of August, 1904, under the presidency of Dr. Simon J. Tunstall of that city. Mr. Mayo Robson will be a guest of the Association. A strong effort should be made for a large representation from the Maritime Provinces. The trip alone will be a great source of education, while the hospitality of the West is difficult to surpass.

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—*The Medical Times and Hospital Gazette.*

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WHOLESALE AND RETAIL. Please mention the MARITIME MEDICAL NEWS.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Jan. 20th. Meeting held at City Hall, the President, Dr. F. W. Goodwin, in the chair.

The auditing committee submitted their report finding the vouchers and accounts correct.

Dr. M. A. B. Smith, by letter, tendered his resignation as a member of the branch. Regret was generally expressed; and it was resolved that the resignation be left on the table till next meeting, and meanwhile Dr. Smith be communicated with, and if possible induce him to reconsider his decision.

The President submitted a sample of linseed meal which one of his patients had procured at a drug store. The meal was of inferior quality, without any oil in it. A sample had been submitted to the Dominion Analyst who reported it below the standard required by law. It was, on motion, resolved that the President ask the price of the meal and if it were sold as good quality.

The discussion on "Antiseptics in Midwifery" was then opened by Dr. M. A. Curry.

Dr. Curry referred to the importance of the subject, and gave the history of the early recognition of puerperal fever by Semmelweis, his efforts to overcome the causes which had made puerperal fever a terrible scourge; how the views of Semmelweis were so heedlessly refuted and himself submitted to inhuman treatment. [An interesting account of Semmelwies, by Dr. A. Rose, will be found in the February issue of the NEWS, page 65.—Ed.]

Dr. Walsh traced the causes of puerperal fever, the introduction of antiseptics, the improved conditions that followed their use, the need of greater cleanliness, and greater watchfulness, the use of a gown while attending the patient to prevent the carrying of any contagious disease, and the exercise of extreme caution in securing sterilized surroundings of room and attendance.

Dr. Mader spoke of the need of instructing the patient in the need of great cleanliness—all articles about the patient to be fresh and

clean, and to banish the idea that "any old thing" would do as far as clothing was concerned. He also referred to gonorrhœa as an important cause of infection, also retained membranes which often occurs when the delivery has taken place before the doctor arrives and the nurse has removed the placenta.

The President thought that sufficient credit had not been given to Dr. Oliver Wendall Holmes for his efforts to create a strong opinion in favor of antiseptic midwifery. He thought his efforts in medicine were more valuable than those in literature.

Dr. Chisholm asked why it was that when nature is left to do its own work harm so seldom follows. He thought vaginal injections were useless if not harmful, that the use of plenty of soap on the hands and hot water would thoroughly remove all micro-organisms. We should aim at aseptic rather than antiseptic midwifery. His experience is that rise of temperature following retained membranes does not usually follow till the eighth or ninth day. The treatment is curetting followed by free douching. Use a large curette, sweeping everything away, then free carbolic acid, followed by alcohol.

Dr. Trenaman spoke of the methods carried on at the lying-in-ward of the Poors' Asylum, which illustrated his own practice—scrubbing of the hands and nails with soap and water and afterwards in a solution of bichloride, also thorough cleansing of the patient's genitals with bichloride. No douches were used before or after labor unless offensive lochia demanded them.

Dr. Hawkins said that great care should be exercised in seeing that the uterus is entirely emptied, that the placenta should be carefully examined, and that anything retained should be removed by the finger or curette. He thought the need of gowns and other paraphernalia did not exist.

Dr. G. M. Campbell said he generally used permanganate as a disinfectant. In cases where there was difficulty in getting the membranes away, delay was advisable—go slowly. It was difficult in puerperal fever to determine between septicæmia and pyæmia.

Dr. Almon instanced cases of puerperal fever in his practice, one in whom the temperature ranged from 102° to 106° for 24 days and recovered. The patient lived at Herring Cove and could not be seen often.

Dr. Ross read a paper by Dr. N. S. Fraser, which had just come to

hand, on "Douches—Vaginal and Uterine." (See January number of the NEWS.)

Dr. Murphy said he was one of the last to give up the vaginal douche in midwifery cases, and had not found any harmful results from it. He alluded to the need in a case of torn perineum of using more than simple skin sutures.

Dr. Hare spoke of his experience in China, and also at the Rescue Home, where he had had 30 cases, puerperal septicæmia developing in three following gonorrhœal infection. He uses lysol in 1 to 2 per cent. Dr. Hare also referred to a country doctor who had had an extremely large practice in midwifery, and was known for his general lack of cleanliness, yet a case of sepsis was unknown in his practice.

Dr Curry, in closing the discussion, said he never used a douche before or after labor, unless there was some indication for it. Lysol was his preference. He deprecated examinations of the uterus after labor. Cleanliness of the patient and surroundings is the great thing to be observed. He always uses a pad in bichloride solution to absorb the discharges. To prevent mastitis he advises having the breasts bathed with alcohol for a month or two before confinement. If cracks appear in the breast he finds the following ointment useful: fifteen grains of resorcin, one dram of tincture benzoin co., to one ounce of lanolin.

FEB. 3RD.—Dr. T. D. Walker of St. John, who was to have read a paper this evening, was unable to be present. Dr. Hattie instead read his paper on "The Mental Complications and Sequelæ of the Infectious Diseases" which was recently read before the St. John Medical Society. (This paper will appear in the NEWS.)

The discussion following was taken part in by most of the members present.

A vote of thanks was presented to Dr. Hattie for his interesting paper.

Dr. G. M. Campbell, was re-appointed to the advisory committee of the Victorian Order of Nurses.

FEB. 17TH.—Meeting held at the Queen Hotel, at 8.30 p. m.

Dr. T. D. Walker of St. John, read a paper on "Hilton's Rest and Pain." Before doing so Dr. Walker expressed his appreciation of the honor done him, in asking him to read a paper before the branch. (This paper will be published in the NEWS.)

The President mentioned cases in his practice, illustrating some of the points brought out in Dr. Walker's paper. The use of conium in fistula and ulcer of the rectum to control the sphincter ani muscle and giving rest was referred to.

Dr. Kirkpatrick spoke of the use of atropia applied to the temporal region, to affect the eye. He had not used it in that way, as instillation was so easy, but he could readily understand how it might apply.

Dr. Jones instanced when being examined for his qualification in London, being asked if he had read Hilton's book on Rest and Pain, saying he had not, the examiner told him he was not fit to commence practice till he had read it.

Dr. Chisholm thanked Dr. Walker for calling attention to the old things in medicine and surgery. We have lost much in neglecting the books of the old days. The newly discovered disease, enteroptosis, was written up forty years ago by a quack called Dr. Fitch, and no other book since has so fully described the history of the disease. Dr. Chisholm described a large abscess about the head of the ulna, which did well after opening and sewing, and giving rest with drainage. Referring to Hilton's method of local applications to reduce pain in a part, turpentine relieved the pain of peritonitis while the free use of a poultice relieved the pain of an abscess by the general dilatation of the blood vessels and thus relieving the congestion.

Dr. Hattie referred to the keenness of Dr. Hilton's powers of observation. And how much more would be accomplished at the present time, if physicians, equipped as they are, were as careful in details as many of the old time observers.

Dr. W. Huntley Macdonald of Antigonish, spoke of Dr. Alonzo Clarke's treatment of peritonitis by the giving of opium in large doses. This was a sequel to Hilton's teaching.

Dr. G. M. Campbell said the two books which he had most thoroughly read and enioyed, were Hilton's, "Rest and Pain," and Fothergill's, "Rational Therapeutics." He was sorry that Dr. Walker's paper had not continued longer: it was all too short.

Dr. C. D. Murray regretted that Dr. Walker had left so little unsaid.

Dr. Ross spoke of the importance of rest in skin diseases. These like other diseases are frequently overtreated.

Dr. Murphy, referred to his experience in the surgical treatment of tubercular glands of the neck. When a large incision was made

and all the glands apparently removed, in the following year it seemed a new set of glands came to view. At the present time he opened the abscesses, drained the pus, and kept the part at rest, with better results.

Dr. Hare said he had read Dr. Hilton's book during a typhoon, on his way to Pekin. He spoke of his experience in the treatment of large ulcers by sectioning a nerve.

Dr. Walker, in reply, was glad to hear such an interesting discussion, and thought it of great importance to keep in touch with the practice of the older men.

Dr. Trenaman moved and Dr. Walsh seconded that the thanks of the branch be tendered to Dr. Walker for his admirable paper, which was carried unanimously, to which Dr. Walker suitably acknowledged.

It was also on motion resolved to send a letter to Dr. Mader, expressing the regret of the branch for his recent serious injury, and their hopes for his complete and successful recovery.

N. S. BRANCH OF BRITISH MEDICAL ASSOCIATION PROGRAMME.

The following is the plan of the agenda for the remainder of the session:

March 30th—Paper by Dr. H. K. McDonald, Lunenburg, N. S. Subject to be announced.

April 13th—"History of Medical Society in Halifax." Paper by Dr. D. A. Campbell.
Discussion on "Diseases of the Prostate Gland," by Drs. Murphy, Ross and others.

Additions and changes to the above programme may be made as occasion arises. Members and all visiting practitioners from all parts are welcome. Any medical gentleman willing to contribute a paper will kindly communicate with the Secretary, Wm. D. Forrest, M. D., Pleasant street, Halifax.

Personals.

Dr. W. H. Macdonald, of Antigonish, has gone on a trip to Bermuda and Jamaica, not having been in good health lately.

Dr. Trenaman, of this city, was recently confined to the house for a few days by illness, but is now fortunately much improved in health.

Next month we will publish an interesting paper by Drs. C. E. Simon, of Baltimore and D. G. J. Campbell, of Halifax, who is now doing post graduate work in Baltimore.

Dr. K. A. MacKenzie, of New Campbellton, recently had a severe attack of appendicitis, from which he has fortunately recovered.

Dr. W. W. Wickham, of Tignish, P. E. I., accompanied by his wife, recently started for Saranac Lake, N. Y. We are sorry to hear of the Doctor's poor health, and trust the change will prove effective.

Obituary.

Dr. D. H. Muir. The death of Dr. D. H. Muir occurred at Truro on the 11th inst, two years and one day after that of his brother, Dr. Will.

David Holmes Muir was the eldest son of the late Dr. Samuel Allen Muir. He was born in Truro in 1848, was educated in the old Model Schools in that town, under Principal J. B. Calkin, and also in the Provincial Normal School, under the late Rev. Dr. Forrester, Superintendent of Education for Nova Scotia. He studied medicine with his father, and finished his medical education by graduating high in his class at the College of Physicians and Surgeons, New York, in 1867. He at once commenced the practice of his profession in Truro, which he has continued with success up to the time when his past severe illness forced him to give up the work he had loved so well.

He was an active good citizen and took a deep interest in the welfare of the town. Served as one of its councillors and for several terms was elected and served as Mayor. He was always an active member of the Truro Board of Trade of which he was President for some years, and frequently represented the Board as a delegate to other localities. He was for years a managing director of the Truro Condensed Milk

and Canning Company, was latterly its President, and enjoyed to a very large extent the confidence and esteen of all connected with that Company.

In politics he was a staunch Conservative and was several times nominated as a standard bearer, and at one by-election only lacked four or five votes of reaching the House of Commons.

Dr. D. H. Muir was married in 1870 to a daughter of the late Hon. J. W. Ritchie. She died in 1895, leaving two sons, John W. Muir, now of Carstairs, N. W. T., and David H. Muir, now a student at McGill, Montreal. Both were at home when their father died.

The funeral obsequies of the late Dr. D. H. Muir took place from St. John's church on March 16th, when hundreds crowded into the church, and lined the streets in the vicinity of St. John's, to pay their last tribute of respect to so prominent and so deeply mourned a citizen.

The pew in St. John's that Dr. Muir had occupied for many years was prettily and artistically adorned with floral tributes, including a wreath from the Provincial Medical Board.

The service in the church was conducted by the Rector of St. John's, Ven. Archdeacon Kaulbach, assisted by Rev. G. R. Martell, Rector of Maitland; at the grave, Rev. J. W. Godfrey, Curate of St. John's, officiated.

Among those from Halifax who were present to to pay their last tribute of respect to his memory were Dr. M. A. B. Smith, Dr. J. Stewart, Dr. G. M. Campbell, Dr. L. M. Murray.

The long prosession, after the church service, then wended its way to Terrace Hill Cemetery, where was deposited "earth to earth," "ashes to ashes," all that was mortal of the well known and much regretted David Holmes Muir.

Book Reviews.

THE DAILY MEDICAL is our newest exchange, having seen the light of day on the 8th ult. The articles are short and to the point, and it is trusted that its aims, as given in its editorial columns, will be accomplished. It is printed by The Medical Publishing Co., of America, 154 East 72nd Sireet, New York, and is only one dollar a year.

A NON-SURGICAL TREATISE ON DISEASES OF THE PROSTATE GLAND AND ADNEXA.—By George Whitfield Overall, A. B., M. D., formerly Professor of Physiology in the Memphis Hospital Medical College. Published by Marsh and Grant Company, Chicago.

The aims of this book are well explained in the introductory chapter and the author's experience gathered from a period of over twenty years suggested to him to publish a practical summary of the methods and

results obtained by clinical experience. Disoases of the prostate and adnexa are to a large extent overlooked by the average practitioner and cases of mistaken diagnosis from the symptoms experienced by the patient are daily seen. Even after a careful diagnosis and carrying out the treatment as advocated in our modern text books, experience has shown that a long period of time is required before marked improvement is seen. Dr. Overall has "devised and perfected instruments with which to apply the combined properties of medicines, electrolysis and cataphoresis for the purpose of stimulating vaso-motor contraction, relieving thereby congestion and inflammation, dissipating morbid tissue and chemically decomposing or breaking up lime or earthly concretions that form in the ducts and follicles of the prostate." The author gives a large number of case reports, showing results of the treatment adopted and evidently proving the success obtained in a large percentage of patients. The illustrations are numerous and well executed and his teachings are well worth deep consideration by all interested in the diseases with which this book deals. The chronicity of affections involving the prostate gland and seminal vesicles is well recognized, and any line of treatment that will prove effectual and particularly shorten their duration cannot but be warmly welcomed. We trust that the experience of others following in a similar line will further prove the good results advocated by the author.

Notes.

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Harrisburg, Ills. J. W. Mitchell, M. D.

The Cough-Sequela of La Grippe.—Dr. John McCarty of Briggs, Texas, (Louisville Medical College) in giving his personal experience with this condition, writes as follows: "Ten years ago I had la grippe severely and every winter since, my cough has been almost intolerable. During January 1902, I received a sample of Antikamnia & Heroin Tablets and began taking them for my cough, which had distressed me all winter, and as they gave me prompt relief, I ordered an ounce box which I have since taken with continued good results. Last fall I again ordered a supply of Antikamnia & Heroin Tablets and I have taken them regularly all winter and have coughed but very little. I take one tablet every three or four hours, and they not only stop the cough, but make expectoration easy and satisfactory."

Necessity Creates the Demamd.—The rapid pace at which the American people are living draws heavily upon the physical bank account. To withstand the demands of nature large quantities of food are consumed and in many instances proper time for digestion is not given. To retain health, elimination of waste products is as important as nutrition and the presence of rheumatism, gout, asthma, sore throat, lithemia, neurasthenia etc., many times indicates that, the organs of elimination are not properly functionating, and that waste products, especially uric acid are being stored up in the system. In these conditions an eliminant and uric acid solvent is indicated and as a remedy which has stood the test of time and rendered most excellent services in these cases, Hayden's Uric Solvent is highly recommended. This preparation is a product of the laboratories of the New York Pharmaceutical Co. Bedford Springs, Mass., who need no introduction to our readers but we mention it as it means "Standard of Merit." Write them for copy of booklet "Human Laboratory."

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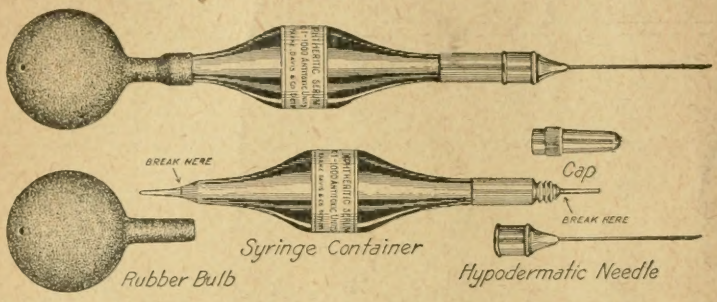

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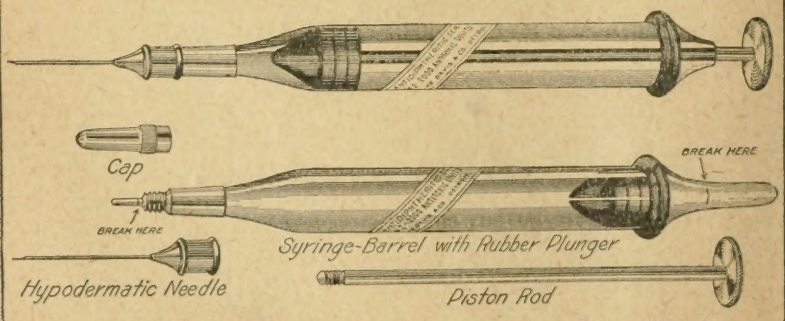

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